DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

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Dear Immunization Program Managers and AFIX Coordinators:

The Assessment, Feedback, Incentive, and eXchange (AFIX) Standards are an outgrowth of the Immunization Program Operations Manual (IPOM). The IPOM presents information to programs on "what an effective immunization program looks like." The AFIX Standards have a similar purpose but focus specifically on the AFIX process. The AFIX Standards are organized in levels, and within each level there are 6 program components (program operations, assessment, feedback, incentives and exchange of information and program evaluation). Each level builds upon the successful completion of the previous level's requirements.

Level I of the AFIX Standards provides structure on how to develop, implement and evaluate an effective AFIX program that will meet all grant requirements. The Standards describe essential elements for all AFIX programs; they are also flexible to allow for grantees to address situations unique to their locale.

The AFIX Standards are designed to encourage but not require grantees to continue to improve beyond a fundamentally sound and effective AFIX program. Levels II and III provide guidance for exceeding the requirements for an effective AFIX program and focus on developing new and creative collaborative relationships with other organizations and immunization providers.

The official release of the complete AFIX Standards document will occur during the National Immunization Conference in Washington, D.C., March 21–24, 2005. Shortly after the conclusion of NIC, each Immunization Program Manager and AFIX Coordinator will receive a binder of the complete set of AFIX Standards, levels I – III. The binder format has been selected so each grantee can easily make copies of the document. The complete set of AFIX Standards will also be available shortly after the NIC on the National Immunization Program (NIP) Website at www.cdc.gov/nip/afix.

Should you have any questions regarding the AFIX Standards, please feel free to contact Nancy Fenlon at (404) 639-8810 or via e-mail at ncf1@cdc.gov.

Sincerely,

Lance E. Rodewald, M.D.
Director
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National Immunization Program

Assessment, Feedback, Incentives and eXchange of Information (AFIX) Standards

Introduction:

AFIX (Assessment, Feedback, Incentive, and eXchange) is a continuous quality improvement tool that consists of: 1) assessment of the health care provider's vaccination coverage levels and immunization practices; 2) feedback of the results to the provider along with recommended strategies to improve coverage levels; 3) motivating the provider through incentives to improve vaccination coverage levels; and 4) exchanging health care information and resources necessary to facilitate improvement. The AFIX methodology is a comprehensive and effective tool for improving the vaccination coverage levels and immunization practices of health care providers. The improved outcomes produced by AFIX through implementation of recommendations and best immunization practices can be quantified through AFIX participation over time. The efficacy of AFIX has been documented in published and unpublished studies[1-4]. Several publications are available on the AFIX website (www.cdc.gov/nip/afix).

Recently, several studies have been conducted to evaluate the implementation of AFIX at the program level. Results from these studies have shown a wide variation in the implementation of AFIX activities with respect to methodology and cost. Furthermore, during the VFC/AFIX Quarterly Conference Calls, participants have expressed dissatisfaction regarding the lack of clearly defined expectations from CDC. Therefore, the Clinic Provider Assessment Workgroup (CPAWG), consisting of AFIX coordinators from state and urban immunization programs and CDC staff, developed standards to assist immunization grantees with implementing and evaluating the AFIX component of the VFC/AFIX initiative.

These standards are intended for use by the grantee program staff overseeing the AFIX program. They are designed to assist the AFIX or Assessment Coordinator/Supervisor in implementing, managing, and evaluating an AFIX program. The standards are specific enough so that grantees can design their programs to fulfill the CDC grant requirements, yet they still offer flexibility so grantees can individualize their programs for the specific conditions in their area. A helpful companion document for these AFIX Standards is the *Core Elements of AFIX Training and Implementation*. The Core Elements document was created as a resource for crafting the specifics of an AFIX visit and is to be used for training AFIX staff on how to conduct an AFIX visit.

[1] Dietz, VJ, Baughman, AL, Dini, EF, Stevenson, JM, Pierce, BK, Hersey, JC. Vaccination practices, policies, and management factors associated with high vaccination coverage levels in Georgia public clinics. *Arch. Pediatr Adolesc Med* 2000; 154: 184-189.

[2] LeBaron, CW, Chaney, M, Baughman, AL, et-al. Impact of measurement and feedback on vaccination coverage in public clinics, 1988-1994. *JAMA* 1997; 277: 631-635.

[3] LeBaron, CW, et-al, Changes in clinic vaccination coverage after institution of measurement and feedback in 4 states and 2 cities. *Arch. Pediatr Adolesc Med* 1999; 153: 879-886.

[4] Massoudi, MS, et-al. Assessing immunization performance of private practitioners in Maine: Impact of the assessment, feedback, incentives, and exchange strategy. *Pediatrics* 1999; 103:6: 1218-1226.

Together, these two tools will allow a grantee AFIX Coordinator/ Supervisor to manage and evaluate an AFIX Program at a program level (using the AFIX Standards) and provide guidelines for training staff new to AFIX (using the Core Elements).

The AFIX Standards have been developed for three levels of an AFIX Program. Standards for a Level I Program focus primarily on the development and implementation of written protocols and procedures and represent the basic components of grant requirements. A Level II AFIX Program builds upon Level I written protocols and procedures designed for its AFIX activities. Standards for a Level II Program focus on improving existing protocols and increasing activity, as well as developing plans for increasing objectives. A Level III AFIX Program builds upon Levels I and II and is developing and implementing innovative strategies for improving the AFIX process. Standards for a Level III Program focus on achieving and maintaining program objectives and conducting evaluation activities to further improve the AFIX process.

It is expected that grantees may be at different levels for one or more of the AFIX components. This manual and the self assessment tool allow grantees to determine how the overall AFIX program develops and matures in their locales. The self-assessment tool can assist grantees with future program planning, implementation and evaluation of their AFIX programs.

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Program Operations Component

Principle
The program operations component provides a foundation for implementing a fundamentally sound AFIX Program that includes methods for planning, implementing and managing an AFIX program. This component will also include clearly defined procedures for training and guiding staff members on AFIX protocols as the program develops over time.

Level I AFIX Program

A Level I AFIX Program should include the following Program Operation standards in the written strategic plan:

1. Clearly defined measurable short and long-term objectives for the AFIX program.
2. Clearly defined methods for evaluating progress at achieving short and long-term objectives. Methods may include: definition of key indicators; frequency of evaluating progress; and time frame for achieving objectives.
3. ✓ ☞[5] Clearly defined methods for annually selecting at least 25% of enrolled VFC providers to receive an AFIX site visit. Methods should include how providers are prioritized (e.g. high-volume practice, never received an AFIX visit, etc) as well as defined criteria for selecting providers in need of annual assessments.
4. Clearly defined methods for identifying and recruiting providers to participate in the AFIX program.
5. Written job descriptions for all staff involved with the AFIX program.
6. Clearly defined procedures for AFIX staff members to follow when issues beyond the scope of AFIX have been discovered. These procedures should include which staff member should be informed of which issue. For example, during an AFIX visit, the field representative identifies a possible case of fraud in the office and follows procedures to notify an appropriate person for follow-up.
7. Clearly defined plan for training AFIX staff members. Plan should include a curriculum for training new employees as well as periodic training updates for existing employees.
8. Clearly defined methods for supervising and monitoring AFIX staff members' progress at conducting the annual AFIX site visits. Methods may include: definition of key indicators for assessing progress and frequency of assessing progress.
9. Clearly defined methods for contacting outside agencies and exploring the possibility of collaborating on quality improvement activities and/or marketing AFIX.

[5] These two symbols are referenced in the Immunization Program Operations Manual and are defined as:
✓Activities that CDC considers high priority
☞Activities required by statute (i.e., Omnibus Budget Reconciliation Act of 1993 and Childhood Vaccine Injury Act of 1986) or necessitated by reports required by CDC

Level II AFIX Program

A Level II AFIX Program should have achieved and implemented all standards in Program Operations Level I as well as include the following standards in the written strategic plan:

1. Annually review all AFIX related protocols and job descriptions and update as needed.
2. Evaluate the feasibility of conducting VFC/AFIX combined visits. If they are found to be effective, create a written plan for making VFC/AFIX combined visits part of your standard protocol. The plan should include:
    a. A measurable objective (e.g., increase combined visits in CY2005 by 15%)
    b. Action steps for achieving the objective
    c. Methods for reviewing the progress towards achieving the objective
    d. A time line for achieving the objective.

    If the program determines combined visits are not appropriate for their area, then a written statement should be included in the AFIX protocol explaining why combined visits are not appropriate.
3. Develop an agreed upon action plan with an outside agency(s) to establish collaboration on quality improvement activities and/or marketing AFIX.

Level III AFIX Program

A Level III AFIX Program should have achieved and implemented all standards in Program Operations Levels I and II as well as include the following standards in the written strategic plan:

1. Develop and implement a written plan to increase the percent of VFC enrolled providers receiving an annual AFIX visit to achieve the Healthy People 2010 assessment goal.[6]
2. Expand collaboration with other health care organizations, such as managed care organizations, to develop methods to reduce provider burden related to multiple record reviews on preventive health services.
3. Assist providers who wish to conduct their own assessments with strategies related to methodology, data collection, analysis, and presentation with practice staff and the immunization program.

[6] (Healthy People 2010. Immunization Goals. Retrieved August 2, 2004 from http://www.healthypeople.gov/hpscripts/KeywordResult.asp?n345=345&Submit=Submit)

4. Initiate collaboration with other programs within the department of health to expand assessment activities beyond immunization. For example, in addition to collecting immunization histories during the chart review, the field staff also collects information on other health services such as lead screening, tuberculosis screening, and/or dental screening. The purpose of this standard is to expand the AFIX process to improve the utilization of other health care services provided to children.

For further information on Program Operations, please refer to resources #1 (Sample AFIX Policies) and #2 (Collaboration) in the Resources section at the end of this document.

Assessment Component

Principle
Assessment provides a standardized method to collect and analyze immunization data to estimate immunization coverage levels. Assessments conducted through a site visit can provide valuable opportunities to assess practice patterns that may encourage or unintentionally discourage the delivery of immunizations to the practice's patient population.

Level I AFIX Program

A Level I AFIX Program should contain the following Assessment standards in the written protocol and be available to AFIX field staff at all times:

1. Clearly defined procedures for contacting providers, scheduling site visits, and documenting communication with providers.
2. Clearly defined assessment parameters, including:
    a. Assessment methodology (hybrid or standard)
    b. Number of records to be included in the sample
    c. Age range of children to be assessed
    d. Inclusion Criteria/Active Patient (it is recommended that the same definition be used for all AFIX activities) [7]
    e. Immunization series to be assessed
    f. Demographic data fields to be collected
    g. Moved or gone elsewhere (MOGE)
3. Clearly defined methods for selecting a sample including the persons responsible for pulling charts. Methods may include procedures for the following scenarios:
    a. Practice has fewer patients than the target sample size
    b. Practice can provide an electronic list of patients
    c. Practice cannot provide an electronic list of patients
4. Separate protocols for assessment procedures (e.g. Hybrid Assessment vs. Standard Assessment) exist if assessment methods differ among provider types (e.g. private vs. public providers). If different assessment procedures are used for different situations, each situation should be described and included in the Assessment Protocol.
5. Clearly defined methods for supervising and monitoring AFIX staff members' implementation of the Assessment Protocol.

[7] Morrow, AL, Crews, RC, Carretta, HJ, Altaye, M, Finch, AB, Sinn, JS. Effect of method of defining the active patient population on measured immunization rates in predominately Medicaid or non-Medicaid practices. Pediatrics 2000; 106:1: 171-176.

Level II AFIX Program

A Level II AFIX Program should have achieved and implemented all standards in Assessment Level I as well as contain the following standards. This written protocol should be available to AFIX field staff at all times:

1. Annually review assessment policies and staff activities to ensure quality assessments are conducted.
2. Coordinate with immunization registry staff.
    a. Establish a working relationship with the registry team to ensure the registry can meet assessment needs.
    b. Develop a written plan that explores the possibility of abstracting registry data in place of chart data for the assessment of immunization practices. (For more information, refer to the Core Elements of AFIX Training and Implementation, Appendix G.)

Level III AFIX Program

A Level III AFIX Program should have achieved and implemented all standards in Assessment Levels I and II as well as contain the following standards. This written protocol should be available to AFIX field staff at all times:

1. Expand activities to include adolescents and adults with written assessment policies for each age group.
2. Implement the use of registry data for assessment in public and private provider offices.
    a. Develop and implement written protocols on which provider sites will be assessed using registry data.
    b. Develop and implement written protocols for continuous monitoring of quality of registry data used for assessments.

For further information on Assessments, please refer to resource #3 (Assessment Methods) in the Resources section at the end of this document.

Feedback Component

Principle
Feedback is the process of informing immunization providers about their performance in providing vaccines to a specifically defined population. This process includes providing information on immunization coverage levels for that provider and facilitating a forum with provider staff to discuss how to improve their immunization delivery system. Input from the provider and office staff is essential to determine what changes are reasonable for the practice to implement.

Level I AFIX Program

A Level I AFIX Program should contain the following Feedback standards in the written protocol:

1. Clearly defined process for coordinating a Feedback session which includes the following items:
   a. Timing: Feedback sessions should occur at the convenience of the provider, preferably within 10 working days of the assessment.
   b. Logistics: Feedback sessions should be a face-to-face meeting with provider staff members unless there is a documented justification for not conducting the session in person.
   c. Participants: Feedback sessions must include at least one key staff member who has the ability to authorize practice changes and ensure that agreed upon changes take place. Sessions should also include as many additional staff as possible.
2. Specific details regarding the presentation, documentation and discussion of the following items during the Feedback session:
   a. Prioritize issues and identify at least 2 opportunities for improvement
   b. Any areas of strength related to the delivery of immunizations
   c. Coverage levels for specific vaccination series and individual antigens
   d. Observations of office practices
   e. Whether or not the provider staff agrees with your assessment of their practice
   f. The improvement strategies the provider staff believes are feasible and relevant for the office to implement
3. Clearly defined process for developing a simple, written quality improvement plan for the opportunities for improvement that the provider agrees to implement. A signed copy of this plan is to be kept by the provider and a copy kept by the AFIX staff member. At a minimum, the plan should include the following key items:
   a. Opportunity for improvement on which to focus
   b. Defined action steps for implementing the intervention
   c. Responsible party for implementation
   d. Date to implement intervention
4. Clearly defined list of items to leave with the provider such as resource materials or informal incentives.

5. Clearly defined process for follow-up with the provider and his/her staff to ensure the agreed upon commitments are completed by the proposed date as outlined in the quality improvement plan.
6. Clearly defined method for evaluation of feedback sessions, which include having a supervisor attend a specified proportion of each employee's feedback visits.

Level II AFIX Program

A Level II AFIX Program should have achieved and implemented all standards in Feedback Level I as well as include the following standards in the written protocol:

1. Develop and implement clearly defined procedures for AFIX field staff to promote continuous quality improvement with providers and staff. For example, once providers have demonstrated improvement in previously identified areas, field staff will help providers identify new opportunities for improvement.
2. Document all provider follow-up communication on proper forms and give copies to the provider as appropriate.
3. Routinely update resource materials for providers.

Level III AFIX Program

A Level III AFIX Program should have achieved and implemented all standards in Feedback Levels I and II as well as include the following standards in the written protocol:

1. Explore and pilot innovative methods for engaging providers and presenting information in feedback sessions.
2. Provide ongoing assistance to providers who are not able to document progress toward targeted areas of improvement.
3. Document the feedback policies and procedures for each age group to be assessed (i.e., adults, adolescents) if the feedback procedure varies with the age group.

For further information on Feedback, please refer to resource #4 (Feedback Sessions Checklist) and #5 (Opportunities for Improvement documents) in the Resources section at the end of this document.

Incentives Component

Principle
Incentives are used to motivate providers and practices to develop more effective immunization delivery systems and ultimately improve immunization coverage levels. Incentives promote change and reward achievement. Incentives may be formal or informal, as described below, to assist or motivate a provider to make practice-based changes and recognize improved performance.

Level I AFIX Program

A Level I AFIX Program should contain the following Incentives standards in the written protocol:

1. Guidelines specifying that two informal incentives will be offered during the feedback session.
2. Clearly defined list of options to use as informal incentives. These incentives may include but are not limited to:
    a. Printed immunization resources such as most current VIS statements and immunization schedule
    b. Offer to provide educational in-services to the staff on a variety of immunization topics
3. Clearly defined formal incentives that acknowledge providers with improved or sustained high immunization coverage levels; these formal incentives may include but are not limited to:
    a. A letter of recognition signed by the governor or the state health officer on official state letterhead
    b. Public recognition of the provider with the greatest immunization coverage level improvement at a state or regional immunization conference or similar forum
4. Clearly defined process describing how the formal incentives are implemented. At a minimum, the protocol must include:
    a. Who is eligible to receive an award and/or recognition
    b. How the award recipients are determined

Level II AFIX Program

A Level II AFIX Program should have achieved and implemented all standards in Incentives Level I as well as contain the following standards in the written protocol:

1. Document incentives offered by field staff and accepted by providers. These informal incentives may include but are not limited to:
    a. Providing in-services on immunization issues to office staff
    b. Working with office on agreed upon immunization activities

2. Identify and utilize at least one potential partner to assist with incentives. Supervisors should coordinate activities with this partner.

3. Implement clearly defined incentives to assist low performing offices in improving their immunization coverage levels. The program policy for incentives should include the following information:
    a. Provider selection
    b. Content
    c. Participation incentives (if any)
    d. Incentives for improved outcomes

Level III AFIX Program

A Level III AFIX Program should have achieved and implemented all standards in Incentives Levels I & II as well as contain the following standards in the written protocol:

1. Document the incentives policies and procedures for each age group that will be assessed (i.e., adults, adolescents) if different incentives are used for different age groups.

eXchange of Information Component

Principle
The exchange of Information is an opportunity to share best practices with and among immunization providers. This exchange can occur informally during the feedback session or through formal avenues, which could include the identification of an "immunization champion." In addition, annual professional gatherings such as public health conferences or state medical association meetings provide opportunities to exchange best practices in immunization services.

Level I AFIX Program

A Level I AFIX Program should contain the following eXchange of Information standards in the written protocol:

1. List of specific information to exchange during the feedback session, including but not limited to:
    a. The current immunization schedule
    b. The current VIS statements
    c. Additional immunization resources (e.g. list of credible immunization websites, schedule of immunization satellite broadcast courses, etc.)
    d. Pertinent standards for practice that are related to the office's strengths and opportunities for improvement
    e. Interventions used in other practices with similar opportunities for improvement
    f. Information on national or state level immunization coverage levels and goals

    This standard differs from Incentive Component Standard #2 in that staff exchange information on how to obtain and use the resource materials in their office.
2. Process used to promote the VFC/AFIX program at health professional meetings or conferences. These meetings or conferences may include but are not limited to:
    a. State or regional immunization conferences
    b. State chapter meetings of medical associations such as American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), or American College of Physicians
    c. Meetings of health care insurers such as Medicaid, Medicare, health systems or managed care organizations (MCOs)
    d. State or regional public health conferences

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Level II AFIX Program

A Level II AFIX Program should have achieved and implemented all standards in eXchange of Information Level I as well as contain the following standards in the written protocol:

1. Document and review the interventions implemented by providers to improve immunization coverage. Share the outcomes with AFIX staff, providers, external partners and other interested individuals or organizations. Utilize, at a minimum, three different methods to exchange this information on an annual basis, and maintain documentation on how the information was exchanged. These methods may include but are not limited to:
    a. Informal discussions during feedback sessions, recorded on the feedback checklist
    b. Written information in a news article or a direct provider mailing or fax
    c. Formal presentations at local meetings, regional, state or national conferences
    d. Informal discussions during meetings with potential VFC providers or potential partners
2. Develop and implement a clearly defined, written plan detailing the process for recruiting high performing offices to become "immunization champions." The "immunization champion" will promote AFIX and quality improvement activities to increase immunization coverage with peers. The strategic plan must include the following components:
    a. How to identify potential "immunization champions"
    b. Recruitment methods
    c. Methods to retain active "immunization champions"
    d. Program oversight of activities

Level III AFIX Program

A Level III AFIX Program should have achieved and implemented all standards in eXchange of Information Levels I and II as well as contain the following standards in the written protocol:

1. Utilize technologies to educate providers on immunizations issues and strategies for improving the delivery of immunizations and other preventive services. (i.e., CDs, computer-based training)
2. Develop and disseminate an annual summary report describing immunization quality improvement activities to providers and other health care agencies. The report content may include but are not limited to:
    a. Summary of visits conducted
    b. Range of coverage levels
    c. Number of providers with improved coverage levels

    d. Case studies of specific providers who implemented new strategies that improved their coverage levels
3. Share lessons learned by becoming a mentor to other state and local immunization programs or by providing technical assistance to the CPAWG committee.
4. Document the methods used to exchange information for age group assessed if different methods are used with the age groups.

Program Evaluation Component

Principle
Program evaluation is an important component to the VFC/AFIX initiative. Just as AFIX is designed to help providers improve immunization delivery practices, program evaluation will help improve the implementation of AFIX. As a program matures, it should develop research questions to determine how all the components of the AFIX process can be improved.

Level I AFIX Program

A Level I AFIX Program should contain the following Evaluation standards in the written protocol:

Standards

1. Utilize an electronic database to monitor site visit activities. Programs may use the database developed by CDC or create their own. At a minimum, the database must be able to generate the summary information that is requested in the Annual VFC Management Survey.
2. Develop a written protocol for utilizing the electronic database. The protocol should include:
    a. Appropriate person(s) identified for entering information into the database
    b. Frequency of updating the database (e.g., weekly, monthly, etc)
    c. Procedures for transmitting data between the field and the central office
    d. Procedures for generating the information needed to complete the VFC Management Survey.
3. Submit Annual VFC Management Survey to CDC in appropriate format by the designated due date.
4. Develop and implement procedures for conducting a process evaluation of the AFIX Program. This may include:
    a. Developing and assessing key indicators to evaluate if internal processes are followed correctly by AFIX staff
    b. Developing and assessing key indicators to evaluate providers' satisfaction with the AFIX site visit in their practices (example surveys can be found at the following address: http://www.cdc.gov/nip/vfc/st_immz_proj/surveys/provider_ex/provider_examples.htm)

Level II AFIX Program

A Level II AFIX Program should have achieved and implemented all standards in Evaluation Level I as well as contain the following standards in the written protocol:

1. Develop methods to document and track the implementation of interventions and outcomes.
2. Annually review the effectiveness of office based interventions. Factors to consider in determining effectiveness are:
    a. Change in coverage levels
    b. Perceived ease of implementation of intervention and time commitment
    c. Amount of AFIX field staff time involved in intervention
    d. Acceptance of intervention by office staff into daily activities
    e. Resources required for intervention to provider and immunization program

Level III AFIX Program

A Level III AFIX Program should have achieved and implemented all standards in Evaluation Levels I and II as well as contain the following standards in the written protocol:

1. Develop, implement and document the impact of "immunization champion" activities on improving immunization coverage levels.
2. Implement written research and evaluation strategic plans that include developing evaluation or research studies focusing on the AFIX strategy. Include timelines for starting and completing each study. Document a periodic review and update of the evaluation and research strategic plans.
3. Periodically develop, implement, and evaluate programmatic changes based on study findings.
    a. Share evaluation findings with other state and local immunization programs annually through at least one of the following venues:
        i. VFC/AFIX Quarterly Conference Calls
        ii. CDC/NIP AFIX website
        iii. National Immunization Conference and/or Program Managers' meeting

AFIX Standards Self-Assessment Tool

The following worksheets are designed as self-assessment tools to assist grantees in identifying the level of each AFIX component currently functioning within their service areas. This self-assessment tool allows each grantee to determine what components of its AFIX program meet or exceed the standards for the different levels. The self-assessment tool can be used as part of a comprehensive strategic plan to build and improve the AFIX program at the local or state level.

Self Assessment Operational Definitions

Level Levels I, II and III represent the different levels of AFIX program activities that can occur within each component. A Level I AFIX Program is a program that is systematically implementing the basic grant requirements of the AFIX program. Standards for a Level I Program focus primarily on the development and initial implementation of written protocols and procedures. A Level II AFIX Program is a program that is actively implementing the written protocols and procedures designed for its AFIX activities. Standards for a Level II Program focus on improving existing protocols and increasing activity, as well as developing plans for increasing objectives. A Level III AFIX Program is an advanced program that has been conducting AFIX activities for some time and is starting to develop and implement innovative strategies for improving the AFIX process. Standards for a Level III Program focus on achieving and maintaining program objectives and conducting evaluation activities to further improve the AFIX process.

Component and Standards Addresses each of the 6 components: Program Operations, Assessment, Feedback, Incentive, eXchange of information and Evaluation. Lists each standard for each level under the appropriate component.

Fully Met The AFIX Program has fully implemented and possibly exceeded the standard.

Partially Met The standard is in the process of being implemented or is implemented in part.

Could Meet The standard could be implemented with low to moderate resource investment, such as changes in policies and procedures, and could be accomplished within the next 6 – 12 months.

Cannot Meet This standard would take a resource investment beyond what is currently available to the program. Implementation of this standard is not planned for at least 24 months in the future.

Next Steps Action items or activities to strengthen or meet the standard.

Self-Assessment Worksheet for AFIX Standards

The AFIX Standards of Operation Workgroup has developed a self-assessment worksheet that Immunization Programs can use to determine the level at which each component of their AFIX program is currently functioning. It allows grantees to determine the components and standards their AFIX Programs meet or exceed at each level. The self-assessment tool can be used to develop a strategic plan for individual AFIX programs.

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I	**Program Operations**					
Clearly defined measurable short and long-term objectives for the AFIX program						
Clearly defined methods for evaluating progress at achieving short and long-term objectives. Methods may include: definition of key indicators; frequency of evaluating progress; and time frame for achieving objectives						
Clearly defined methods for annually selecting at least 25% of enrolled VFC providers to receive an AFIX site visit. Methods should include how providers are prioritized (e.g. high-volume practice, never received an AFIX visit, etc) as well as define criteria for selecting providers in need of annual assessments.						
Clearly defined methods for identifying and recruiting providers to participate in AFIX						
Written job descriptions for all staff involved with the AFIX program.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I (cont.)	**Program Operations**					
Clearly defined procedures for AFIX staff members to follow when issues beyond the scope of AFIX have been discovered. These procedures should include which staff member should be informed of which issue. For example, during an AFIX visit, the field rep. identifies a possible case of fraud in the office and follows procedures to notify an appropriate person for follow-up.						
Clearly defined plan for training AFIX staff members. Plan should include a curriculum for training new employees as well as periodic training updates for existing employees.						
Clearly defined methods for supervising and monitoring AFIX staff members' progress at conducting the annual AFIX site visits. Methods may include: definition of key indicators for assessing progress and frequency of assessing progress.						
Clearly defined methods for contacting outside agencies and exploring the possibility of collaborating on quality improvement activities and/or marketing AFIX.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
II	**Program Operations**					
Annually review all AFIX related protocols and job descriptions and update as needed.						
Evaluate the feasibility of conducting VFC/AFIX combined visits. If they are found to be effective create a written plan for making VFC/AFIX combined visits part of your standard protocol. a. Measurable objective (e.g. Increase combined visits in CY2005 by 15%) b. Action steps for achieving objective c. Methods for reviewing progress towards achieving objective d. Time line for achieving objectives **OR**						
If the program does not think combined visits are appropriate for their area, then a written statement should be included in their material explaining why combined visits are not appropriate.						
Develop an agreed upon action plan with outside agency(s) to establish collaboration on Quality Improvement activities and/or marketing AFIX						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
III	**Program Operations**					
Develop and implement a written plan to increase the percent of VFC enrolled providers receiving an annual AFIX visit to achieve the Healthy People 2010 assessment goal.						
Expand collaboration with other health care organizations, such as managed care organizations, to develop methods to reduce provider burden related to multiple record reviews on preventive health services						
Assist providers who wish to conduct their own assessments with strategies related to methodology, data collection, analysis, and presentation with practice staff and the immunization program						
Initiate collaboration with other programs within the department of health to expand assessment activities beyond immunization. For example, in addition to collecting immunization histories during the chart review, the field staff also collects information on other health services such as lead screening, tuberculosis screening, and/or dental screening. The purpose of this standard is to expand the AFIX process to improve the utilization of other health care services provided to children.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I	**Assessment**					
Clearly defined procedures for contacting providers, scheduling site visits, and documenting communication with providers.						
Clearly defined assessment parameters:						
Assessment methodology (hybrid, standard)						
# of records to be included in the sample						
Age range of children to be assessed						
Inclusion Criteria/Active Patient (it is recommended that the same definition be used for all AFIX activities)						
Immunization series to be assessed						
Demographic data fields to be collected						
Moved or gone elsewhere (MOGE)						
Clearly defined methods for selecting a sample, including the persons responsible for pulling charts. Methods may include procedures for the following scenarios:						
Practice has fewer patients than the target sample size						
Practice can provide an electronic list of pts. OR Practice cannot provide an electronic list of pts.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I (cont.)	**Assessment**					
Separate protocols for assessment procedures (e.g. Hybrid Assessment vs. Standard Assessment) exist if assessment methods differ among provider types (e.g. private vs. public). If different assessment procedures are used for different situations, each situation should be described and included in the Assessment Protocol.						
Clearly defined methods for supervising and monitoring AFIX staff members' implementation of the Assessment Protocol.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Full Met	Partially Met	Could Meet	Cannot Meet	
II	**Assessment**					
Annually review assessment policies and staff activities to ensure quality assessments are conducted.						
Coordinate with immunization registry staff. Establish a working relationship with the registry team to ensure the registry can meet assessment needs. Develop a written plan that explores the possibility of abstracting registry data in place of chart data for the assessment of immunization practices.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
III	**Assessment**					
Expand activities to include adolescents and adults with written assessment policies for each age group.						
Implement the use of registry data for assessment in public and private provider offices.						
a. Develop and implement written protocols on which provider sites will be assessed using registry data.						
b. Develop and implement written protocols for continuous monitoring of quality of registry data used for assessments.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I	**Feedback**					
Clearly defined process for coordinating a Feedback session which includes the following items:						
Timing: Feedback sessions should occur at the convenience of the provider, preferably within 10 working days of the assessment.						
Logistics: Feedback sessions should be a face-to-face meeting with provider staff members unless there is a documented justification for not conducting the session in person.						
Participants: Feedback sessions must include at least one key staff member who has the ability to authorize practice changes and ensure that agreed upon changes take place. Sessions should also include as many additional staff as possible.						
Specific details regarding the presentation, documentation and discussion of the following items during the Feedback session:						
Prioritize issues and identify at least 2 opportunities for improvement						
Any areas of strength related to the delivery of immunizations						
Coverage levels for specific vaccination series and individual antigens						
Observations of office practices						
Whether or not the provider staff agrees with your assessment of their practice						
The improvement strategies the provider staff believes are feasible and relevant for the office to implement						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I (cont.)	Feedback					
Clearly defined process for developing a simple, written quality improvement plan for the opportunities for improvement that the provider agrees to implement. A signed copy of this plan is to be kept by the provider and a copy kept by the AFIX staff member. At a minimum, the plan should include the following key items:						
Opportunity for improvement on which to focus						
Defined action steps for implementing the intervention						
Responsible party for implementation						
Date to implement intervention						
Clearly defined list of items to leave with the provider such as resource materials or informal incentives.						
Clearly defined process for follow-up with the provider and his/her staff to ensure the agreed upon commitments are completed by the proposed date as outlined in the quality improvement plan.						
Clearly defined method for evaluation of feedback sessions, which include having a supervisor attend a specified proportion of each employee's feedback visits.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
II	**Feedback**					
Develop and implement clearly defined procedures for AFIX field staff to promote continuous quality improvement with providers and staff. For example, once providers have demonstrated improvement in previously identified areas, field staff will help providers identify new opportunities for improvement.						
Document all provider follow-up communication on proper forms and give copies to the provider as appropriate.						
Routinely update resource materials for providers.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
III	**Feedback**					
Explore and pilot innovative methods for engaging providers and presenting information in feedback sessions						
Provide ongoing assistance to providers who are not able to document progress toward targeted areas of improvement.						
Document the feedback policies and procedures for each age group to be assessed (i.e.; adults, adolescents) if the feedback procedure varies with the age group.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I	**Incentives**					
Guidelines specifying that two informal incentives will be offered during the feedback session.						
Clearly defined list of options to use as informal incentives. Examples may include:						
Printed immunization resources such as most current VIS statements and immunization schedule						
Offer to provide educational in-services to the staff on a variety of immunization topics						
Clearly defined formal incentives that acknowledge providers with improved or sustained high immunization coverage levels; Examples may include but are not limited to:						
A letter of recognition signed by the governor or the state health officer on official letterhead						
Public recognition of the provider with the greatest immunization coverage level improvement, such as at a state or regional immunization conference						
Clearly defined process describing how the formal incentives are implemented; at a minimum, the protocol must include:						
Who is eligible to receive an award and/or recognition						
How the award recipients are determined						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
II	**Incentives**					
Document incentives offered by field staff and accepted by providers. These informal incentives may include but are not limited to:						
Providing in-services on immunization issues to office staff						
Working with office with agreed upon immunization activities						
Identify and utilize at least one potential partner to assist with incentives. Supervisors should coordinate activities with this partner.						
Implement clearly defined incentives to assist low performing offices in improving their immunization coverage levels. The program policy for incentives should include the following information:						
Provider selection						
Content						
Participation incentives						
Incentives for improved outcomes (if any)						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				
III	Incentives	Fully Met	Partially Met	Could Meet	Cannot Meet	
Document the incentives policies and procedures for each age group that will be assessed (i.e.; adults, adolescents) if different incentives are used with the age groups.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I	**eXchange of Information**					
List of specific information to exchange during the feedback session, including but not limited to:						
The current immunization schedule						
The current VIS statements						
Additional immunization resources (e.g. list of immunization websites, schedule of immunization satellite broadcast courses, etc)						
Pertinent standards for practice that are related to the office's strengths and opportunities for improvement						
Interventions used in other practices with similar opportunities for improvement						
Information on national or state level immunization coverage levels and goals						
Process used to promote the VFC/AFIX program at health professional meetings or conferences. These meetings or conferences may include but are not limited to:						
State or regional immunization conferences						
State chapter meetings of medical associations such as AAP, AAFP, or ACP						
Meetings of health care insurers such as Medicaid, Medicare, health systems or MCOs						
State or regional public health conferences						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
II	eXchange of Information					
Document and review the interventions implemented by providers to improve immunization coverage. Share the outcomes with AFIX staff, providers, external partners and other interested individuals or organizations. Utilize, at a minimum, three different methods to exchange this information on an annual basis, and maintain documentation on how the information was exchanged. These methods may include:						
Informal discussions during feedback sessions- recorded on the feedback checklist						
Written information in a news article or a direct provider mailing or fax						
Formal presentations at local meetings, regional, state or national conferences						
Informal discussions during meetings with potential VFC providers or potential partners						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
II (cont.)	eXchange of Information					
Develop and implement a clearly defined, written plan detailing the process for recruiting high performing offices to become "immunization champions." The "immunization champion" will promote AFIX and quality improvement activities to increase immunization coverage with peers. The strategic plan must include the following components: How to identify potential "Immunization champions" Recruitment methods Methods to retain active "Immunization champions" Program oversight of activities						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
III	**eXchange of Information**					
Utilize technologies to educate providers on immunizations issues and strategies for improving the delivery of immunizations and other preventive services. (i.e., CDs, computer-based training)						
Develop and disseminate an annual summary report describing immunization quality improvement activities to providers and other health care agencies. The report content may include but are not limited to: a. Summary of visits conducted b. Range of coverage levels c. Number of providers with improved coverage levels d. Case studies of specific providers who implemented new strategies that improved their coverage levels						
Share lessons learned by becoming a mentor to other state and local immunization programs or by providing technical assistance to the Clinic Provider Assessment Workgroup						
Document the methods used to exchange information for age group assessed if different methods are used with the age groups.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I	**Program Evaluation**					
Utilize an electronic database to monitor site visit activities. Programs may use the database developed by CDC or create their own. At a minimum, the database must be able to generate the summary information that is requested in the Annual VFC Management Survey.						
Develop a written protocol for utilizing the electronic database. The protocol should include:						
Appropriate person(s) identified for entering information into the database						
Frequency of updating the database (e.g. weekly, monthly, etc)						
Procedures for transmitting data between the field and the central office						
Procedures for generating the information needed to complete the VFC Management Survey.						
Submit Annual VFC Management Survey to CDC in appropriate format by the designated due date.						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
I (cont.)	**Program Evaluation**					
Develop and implement procedures for conducting a process evaluation of the AFIX Program. This may include: Developing and assessing key indicators to evaluate if internal processes are followed correctly by AFIX staff Developing and assessing key indicators to evaluate provider's satisfaction with the AFIX site visit in his/her practice (example surveys can be found at the following address: http://www.cdc.gov/nip/vfc/st_immz_proj/surveys/provider_ex/provider_examples.htm						

Level	Component & Standard	Fully Met	Partially Met	Could Meet	Cannot Meet	Next Steps
II	**Program Evaluation**					
Develop methods to document and track the implementation of interventions and outcomes.						
Annually review the effectiveness of office based interventions. Factors to consider are: Change in coverage levels Perceived ease of implementation of intervention and time commitment Amount of AFIX field staff time involved Acceptance of intervention by office staff into daily activities Resources required for intervention to provider and immunization program						

Level	Component & Standard	Self-Assessment (✓ appropriate status)				Next Steps
		Fully Met	Partially Met	Could Meet	Cannot Meet	
III	**Program Evaluation**					
Develop, implement and document the impact of "immunization champion" activities on improving immunization coverage levels.						
Implement written research and evaluation strategic plans that include developing evaluation or research studies focusing on the AFIX strategy. Include timelines for starting and completing each study. Document a periodic review and update of the evaluation and research strategic plans.						
Periodically develop, implement, and evaluate programmatic changes based on study findings. Share evaluation findings with other state and local immunization programs annually through at least one of the following venues:						
VFC/AFIX Quarterly Conference Calls						
CDC/NIP AFIX website						
National Immunization Conference and/or Program Managers' meeting						

AFIX RESOURCES

1. **AFIX Policy Examples**

2. **Collaboration: Hints and Examples**
    1. Using the Internet
    2. Contacting organizations
    3. Immunization Project collaboration example

3. **Assessment Methods**
    1. Assessment method options

4. **Feedback Sessions Checklist**

5. **Opportunities for Improvement**
    1. Intervention Handouts
    2. Worksheet

Resource 1 AFIX Policy Examples

The following table of contents and written policy are provided as examples of content and layout for the grantees. In this policy example, the assessment standards addressed are referenced in italics to illustrate how a written policy can capture specific Level I Standards.

These are only examples and grantees should check with their program to determine if there are specific requirements for the formatting of policies within their agencies. Grantees may also contact other grantees for additional written policy examples.

EXAMPLE

AFIX Policy Manual Table of Contents

Policy Number	Policy Name	Section
	Overview of AFIX Project	Overview
#1.0	AFIX Coordinator	Program Operations
#1.1	AFIX Field Representative	Program Operations
#1.2	AFIX Visit Assignments	Program Operations
#1.3	Monthly Staff Visit Reports	Program Operations
#1.4	Joint Supervisory Visits	Program Operations
#1.5	New Employee Orientation	Program Operations
#1.6	Employee Mentoring Program	Program Operations
#1.7	Resources	Program Operations
#1.8	Provider Selection	Program Operations
#2.0	Scheduling an AFIX Visit	Assessment
#2.1	Conducting the Assessment	Assessment
#3.0	Conducting the Feedback Session	Feedback
#3.1	Developing an Office based Quality Improvement Plan	Feedback
#3.2	Post Feedback Follow up	Feedback
#4.0	Utilization of Provider Incentives during the Feedback Session	Incentives
#4.1	Recognition of Improved/High Coverage through Formal Incentives	Incentives
#5.0	Exchange of Information during Feedback Session	Exchange of Information
#5.1	Formal Exchange of Information	Exchange of Information
#5.2	Promotion/Marketing of AFIX	Exchange of Information
#6.0	VFC/AFIX Evaluation Software	Program Evaluation
#6.1	Provider Satisfaction Survey	Program Evaluation

Policy Number: 2.1 Conducting the Assessment

Purpose: To provide a standardized assessment policy for all staff and contractors who conduct AFIX quality improvement activities in both public and private health care settings.

Policy: The following assessment policy will be implemented as written by all staff and contractors conducting AFIX quality improvement activities.

1. Provider Selection for participation in the AFIX project will be based on the criteria documented in policy # 1.8: Provider Selection. ***(Addresses Program Operation Standard 3,4)***

2. Provider will be contacted and AFIX visit scheduled according to policy # 2.0: Scheduling an AFIX visit. ***(Addresses Assessment Standard 1)***

3. All staff will utilize the following assessment parameters during manual chart assessments:
   a. Standard CASA with a 50 record sample (If office has 50 or fewer children in age range, enter all children in the age range into the assessment.)
   b. Sample age range is 24-35 months of age as of assessment date.
   c. For the purposes of the AFIX project, Moved or Gone Elsewhere (MOGE) will be defined as any child in the sample with any one of the following types of documentation in the medical record before 24 months of age:
      - Child transferred to a new practice as evidenced by a provider note or request for records
      - A mailed reminder card sent to the parents or guardians returned by the post office with no new local forwarding address
      - A documented telephone or other contact indicating that the family is no longer at the address of record
   d. An active patient will be defined as any child with one or more well-child visits since birth with no documentation of being a MOGE.
   e. For the purposes of the AFIX project, the following demographic variables will be collected for each child in the sample:
      - Last name
      - First name
      - Zip code
      - Date of birth
      - VFC eligibility
      - VFC documentation
   f. For the purposes of the AFIX project, the following immunization series will be measured for up-to-date status at 24 months:
      - 4DTaP-3Polio-1MMR-3Hib-3HepB- 1Varicella **(*Addresses Assessment Standard 2*)**

4. All staff will use the following sampling guidelines to pull the children in the sample for the assessment component, if the population is greater than 50:

- If provider is able generate list of all patients 24-35 months of age and provide the list to you 7-10 working days before the visit date, use a random numbers table to generate the list of 50 children to be sampled and fax sample list back to the office no later than 5 working days prior to visit date (refer to Core Elements of AFIX Training and Implementation for information on sampling methods.)

- If provider is unable to generate a list of children but is willing to allow you to pull the charts, the Shelf Method will be used as the sampling methodology. (This method is described in more detail in Appendix F of the Core Elements of AFIX Training and Implementation.)

- If the provider is unable to generate a list of children and is not willing to allow you to pull the charts then instruct the office to pull the charts using the Shelf Method.

- If the provider is unable to generate a list of children, is not willing to allow you to pull the charts, and is unwilling to utilize the shelf method, then instruct the office to pull the charts using the Appointment Book. (This method is described in more detail in Appendix F of the Core Elements of AFIX Training and Implementation.) **(Addresses Assessment Standard 3)**

5. Enter dose data from charts into CASA

6. After the data are entered, at minimum review the following CASA reports to determine strengths and areas of opportunities:
   Diagnostic Report
   CASA Summary Report
   Single Antigen Report

7. All new staff and new contract staff will participate in a supervised assessment visit between day 60-120 of employment to ensure that new staff (health department and contract) are implementing the assessment component of AFIX appropriately. **(Addresses Assessment Standard 5)**

8. Prior to incumbent staff annual performance review, staff will participate in a supervised assessment visit to ensure that staff members are implementing the assessment component of AFIX appropriately. **(Addresses Assessment Standard 5)**

Authorizing Signature:_____ Date Implemented: _____

Annual Review Date: _____ Revision Date: _____

Note: **Assessment Standard #4 not applicable**

Resource 2 Getting Started with Collaboration: Hints and Examples

The following helpful hints section and Power Point slides are provided as examples of how to start collaborating with outside organizations on AFIX activities. The helpful hints section provides the user with ideas on how to identify potential collaborators, how to organize your first contact and how to develop an agenda for the first face-to-face meeting with a potential collaborator.

The Power Point slides illustrate how one project collaborated with a large insurer in the state to promote AFIX and the lessons learned from the initial collaboration experience.

Resource 2.1 Using the Internet to Learn More about Potential Collaborators

1. Use your network of immunization contacts to identify health care organizations that serve the population of interest and may be strong candidates for collaboration such as:
    - –Medicaid/Medicare
    - –Commercial Insurers in your program area
    - –Physician organizations
        - –American Academy of Pediatrics website has links to state chapter websites

2. If possible, locate and visit the website(s) of a potential collaborator(s)

3. Identify shared goals or common activities discussed on the website
    - –Some key terms that might lead to potential AFIX collaboration include:
        - – Children's Services
        - – Clinical Guidelines
        - – Clinical Indicators
        - – Immunizations
        - – Medical Services
        - – Performance Measures
        - – Preventive Services
        - – Provider Services
        - – Quality Improvement
        - – Well-Baby Services

4. Review content of website in these areas to determine shared goals or common activities.

5. Answer the following question: "Could the AFIX process potentially assist this organization's activities?" If you answer yes, identify a potential contact person to discuss possible collaboration opportunities.

Resource 2.2 Contacting Organizations Regarding Collaboration

1. It is always helpful to have an outline of key points on why collaboration would be beneficial to both organizations when contacting potential collaborators.

2. When preparing the outline focus on a positive win-win scenario. Strategically address the benefits to the potential collaborator near the beginning of your conversation. When developing your key points, use terminology from the website to support your idea/offer of collaboration. For example, one insurance website (identifiers were removed) stated the following commitment to childhood immunizations and interventions for improving coverage levels:

   Childhood Immunizations

   - **HMO in State X is attempting to increase the number of children receiving age-appropriate immunizations.**
   - **Immunization schedules are published in member newsletters.**
   - **Postcards are sent to parents of children who are 16 months and 20 months old about preventive exams and immunizations.**
   - **Physicians and other professional providers receive updated immunization schedules.**

   Several other areas in this website mentioned the importance of childhood immunization based on this information; it appears this organization would make an excellent candidate for collaborating with the state's AFIX activities.

3. When organizing your collaboration call, use the website information to engage the organization in a collaborative discussion using their quality improvement commitment to childhood immunization coverage as an ice breaker. The introduction/background should mention the organization's commitment and active interventions to enrolled members and contracted providers to improve childhood immunization coverage levels. A possible collaboration call could start something like the following example:

   "I recently visited your Managed Care Organization's (MCO) website and was pleased to read about your commitment to quality improvement activities and especially about your interventions focusing on childhood immunizations. As you may be aware, the state's immunization program actively works with both public and private health care providers to improve childhood immunizations coverage levels in the state. After visiting your company's website, I have a few ideas on how we can possibly work together to improve immunization coverage levels in your contracted provider offices in a cost effective manner for your organization. Can we schedule a time to meet to talk about these ideas?"

4. Once you have scheduled a meeting date, the next activity is to organize your thoughts on collaborative opportunities. One way to organize your thoughts is through the development of a meeting agenda. Below is an example of a simple draft agenda for this type of meeting:

Agenda
MCO-AFIX Collaboration Opportunities

1. **Purpose and Background**
2. **Collaboration Opportunities**
3. **Benefits to MCO and Immunization Program**
4. **Discussion**
5. **Next Steps/Follow-up/Timeline**

5. It is a good idea to further develop the agenda with bullet points of key ideas/concepts to discuss under each agenda item for your personal reference during the meeting. For example, during **Purpose and Background** some key concepts for discussion include:

•Overview of VFC/AFIX Initiative
•Shared populations
•Common quality improvement goal

Repeat this process with each agenda topic but be mindful of the time limit for this meeting and keep the discussion focused on the main concepts.

6. An example of an advanced agenda:

Agenda
MCO-AFIX
Collaboration Opportunities

1. **Purpose and Background**
   - **•Overview of VFC/AFIX Initiative**
   - **•Shared populations**
   - **•Common quality improvement goals**

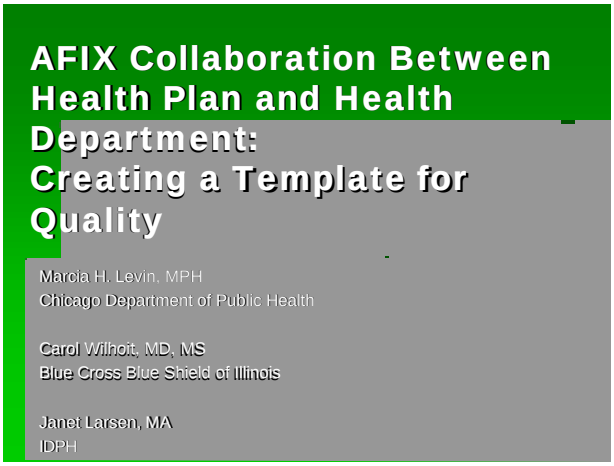
2. **Collaboration Opportunities**
   - **•Simple Opportunities (Short term, minimal planning)**
     - **-Website resources (current schedule, web links)**
     - **-Clinical guideline development/review**
     - **-Provider newsletter**
     - **-Member newsletter**
     - **-Office manager forum**
     - **-External Provider workshop**
     - **-MCO staff education (medical services/ provider services/ member services)**
     - **-Immunization resources through health department/CDC**
   - **•Complex Opportunities (long term)**
     - **-Provider referral to health department for AFIX services**
     - **-Participation in AFIX with certain results would substitute for certain MCO quality improvement activities**
     - **-Use a multi-focused AFIX process to improve other MCO quality indicators along with immunizations to decrease provider burden related to record reviews**

3. **Benefits to MCO and Immunization Program**
    - **MCO Benefits**
        - **Free expert information on Immunizations for a variety of QI activities**
        - **Process in place to assist providers struggling with low immunization coverage levels by referring to health department for AFIX services**
        - **Improve HEDIS scores**
        - **Potential to decrease provider burden related QI activities and decrease MCO's cost around QI activities**
    - **Health Department Benefits**
        - **New opportunity to promote AFIX activities**
        - **Support from health insurer for AFIX activities**
        - **Access to private providers**

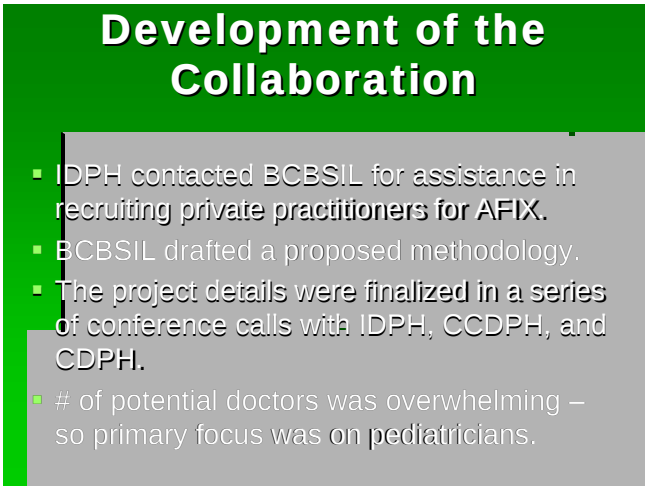
4. **Discussion**
    - **Are there opportunities to collaborate short term and/or possibly long term?**

5. **Next Steps/Follow-up/Timeline**

The meeting's time schedule will not allow you to discuss all the potential collaboration opportunities in depth. A good strategy is to focus on 3-4 short term and simple activities and obtain agreement on those activities. You may briefly discuss possible ideas for long-term, complex collaboration activities depending on the organization's response to the short-term activities.


AFIX Collaboration Between Health Plan and Health Department:
Creating a Template for Quality
Marcia H. Levin, MPH
Chicago Department of Public Health
Carol Wilhoit, MD, MS
Blue Cross Blue Shield of Illinois
Janet Larsen, MA
IDPH


HMOs of BCBSIL
900,000 members – 27,000 < 2 yrs of age
800 pediatricians, 1100 family practitioners
Contract with MG/IPAs, not individual MDs
Childhood immunization was the only HEDIS measure for which the HMO rate remained below the HMO Quality Compass National Average
The MG/IPA contract includes a QI Fund


Development of the Collaboration
IDPH contacted BCBSIL for assistance in recruiting private practitioners for AFIX.
BCBSIL drafted a proposed methodology.
The project details were finalized in a series of conference calls with IDPH, CCDPH, and CDPH.
# of potential doctors was overwhelming – so primary focus was on pediatricians.

Project Methodology- Health Plan Perspective

- BCBSIL motivated MG/IPAs with payment, based upon the % of pediatricians who:
  - had AFIX assessment (60-200 records), and
  - had feedback session with MD participation
- Also required: MG/IPA committee review, with corrective action plan for rates <60%
- One assessment done per group practice
- AFIX included all children seen in the practice – not just BCBSIL members.

BCBSIL Project Timeline

11/01	Project added to 2002 contract between BCBSIL and MG/IPAs, with details in contract attachment
1/1/02 - 3/15/02	Doctors submitted Intent to Participate form
4/02	BCBSIL sent database with MD list to IDPH
7/1/01-12/31/02	AFIX assessments and feedback sessions were done by IDPH, CCDPH and CDPH.
By 2/15/03	MG/IPA submitted participation summary, copies of AFIX assessment, committee minutes, and corrective action plans
3/2003	BCBSIL payment due to MG/IPAs

Project Methodology- Health Department Perspective

- Assess local resources among HD participants
- Determine HD needs and goals
- Address differing levels of technology
- Establish assessment protocol
- Create communication system between HP and HDs
- Assign roles and responsibilities

Impact of Project

- 57 of 78 MG/IPAs participated (73%).
- State-wide, the project assessed 613 physicians in >350 practices.
- 613 of 1020 (60%) of eligible physicians participated.
- Immunization records of >25,000 children were assessed.
- Most of the practices were assessed for the first time.

Examples of Corrective Action Plans

Required for Practices with 24-month Rates < 60%

- Example 1:
  - IPA to assess office by 1/03, with assessment of implementation of IDPH recommendations
  - IPA monthly audit of immunizations at 19 months, with report to MD office
  - IPA to assist office in development of tracking system and member follow-up system
- Example 2:
  - Initiate automated reminder/ recall phone system

Examples of Corrective Action Plans

- Example 3
  - MG/IPA re-reviewed records and found that HD had missed some immunizations
  - Therefore, the group does not intend to participate in future HD audits.
  - However, the MDs recognized the need to focus on 18-month immunizations and will send outreach mailings to parents of children approaching 18 months.

The Collaboration Was Positive: Health Department Perspective

- Gained access to new practices
- Recruited for VFC program
- Crafting of local AFIX programs –
  - Developed flow for assignment of work
  - Designed improved written feedback
  - Sharpened skills for making recommendations/strategies for improvement
- Promoted immunization registry

Corrective Action Plan Feedback

- Corrective action plan allowed HD to determine effectiveness of A & F
- Specific comments were highly illuminating for evaluation purposes
  - Feedback session scheduling
  - Accuracy of HD reports including data collection

The Collaboration Was Positive: The Collaboration Was Positive: Health Department Perspective

- Strengthened role of LHD with practices
  - Surveillance for VPDs
  - Improved immunization practices with educational program and resource materials
  - Targeted providers in high risk communities with additional support-outreach for children missing immunizations
  - Established dialogue for all VFC related issues

The Collaboration Was Positive: BCBSIL Perspective

- Each practice received feedback about immunization rate from a third party
- Health departments did the record reviews
- Valuable to interact with health department
- Feedback about whole practice – not just BCBSIL – more likely to stimulate change
- Good first step towards performance-based payment based on the group's childhood immunization rate

Barriers and Challenges
Barriers and Challenges

- Inefficiency of separate feedback visit
- Variable format of reports
- Multiple health departments:
  - challenge to track visits completed
  - need for comprehensive coordination
- Health department staff lacked technology:
  - couldn't manipulate Access database
  - couldn't print reports onsite
- Health departments had to address other issues:
  - West Nile Virus, Anthrax, Smallpox

Conclusions
Conclusions

- A health plan and multiple health departments can successfully collaborate to increase the number and scope of AFIX assessments in private practices.
- The project laid the groundwork for 2003 BCBSIL payment based on the MG/IPA immunization rate for 2-year olds.
- NEXT STEPS – the health departments continue to cultivate new relationships

Resource 3 Assessment Methods

The assessment methods described below are the ONLY options for grantees using CASA. Grantees cannot mix the standard and hybrid methods. Only one method can be used during a single assessment. Terminology such as "Classic CASA and Mini CASA" will no longer be used. CASA is not an assessment method. CASA is a software application that will assist in conducting an assessment. Below are the options for conducting an assessment as part of AFIX activities.

1. Chart-based Assessment

a. Standard Assessment

The Standard method for conducting an assessment offers two options. Ideally, all records in the selected age group would be included in the assessment. This complete review of all records in the specified age range will provide the most accurate assessment results. If the total number of patients in the specified age range is under 50, a total review is the best option.

When the total number of patients in the specified age range is over 50, a Standard assessment can be conducted using a randomly selected sample of patient charts. An estimated vaccination coverage level based on the information obtained from the charts can be calculated.

The Standard assessment method provides immunization coverage levels for the assessed provider site as well as diagnostic information on patients with missed opportunities, late starts, etc. CASA should be used ***only*** for the Standard Assessment method.

b. Hybrid Assessment

The Hybrid assessment method may also be used for conducting assessments. This method involves reviewing exactly 30 charts. The Hybrid method can only identify whether a provider's coverage is above or below a selected threshold level rather than calculate an estimated immunization coverage level. Coverage levels ***cannot*** be determined using the Hybrid Assessment method. Diagnostic information regarding missed opportunities, late starts, drop-offs, etc can only be used to provide case-by-case examples. Individual medical charts should be reviewed with the provider in an effort to highlight immunization practices that might improve coverage levels. VFC-CASA, which is a different software product than CASA, must be used for the Hybrid assessment method.

B. Registry-based Assessment

A registry-based assessment utilizes data from an immunization registry. This method generally assesses a pre-defined population rather than a sample of that population. The immunization data can be analyzed with available assessment functions built into the registry (if available) or the data can be exported from the registry and imported into CASA for analysis.

Resource 3.1 Assessment Method Options

Method	Description	Advantages	Disadvantages
Chart Based: Standard Assessment	**OPTION #1:** Number of Charts: all eligible records within a specified age group* Method for Selecting Charts: select all records within the specified age range Software to Use: **CASA** Information Entered into Software: child's demographic information; date of each immunization; other information related to diagnostic analysis Software generated outcomes: immunization coverage level, diagnostic information on late starts, drop-offs, missed opportunities, etc	◆ Precise estimates of immunization coverage levels ◆ Evaluation of missed opportunities ◆ Evaluation of late starts, etc.	◆ Can be a resource burden (staff, time) if the entire group of children in the specified cohort is large.
Chart Based: Standard Assessment	**OPTION #2:** Number of Charts: minimum of 50 medical charts selected in specified age group that will be assessed on the same immunizations (i.e. 50 children 12-23, 19-35 or 24-35 rather than selecting 50 charts for children 12-35 months of age.) Method for Selecting Charts: random sample, systematic random sample, shelf method or convenience sample Software to Use: **CASA** Information Entered into Software: child's demographic information; date of each immunization; other information related to diagnostic analysis Software generated outcomes: immunization coverage level, diagnostic information on late starts, drop-offs, missed opportunities, etc	◆ Use of sample reduces time pulling charts and entering data.	◆ Coverage level produced is an estimate. ◆ The sample may not be randomly selected.
Chart Based: Hybrid Assessment	Number of Charts: 30 charts for children 19-35 months of age only Method for Selecting Charts: random sample, systematic sample, shelf method, or convenience Software to Use: **VFC-CASA** (NOT CASA) Information Entered into Software: selected demographic information, number of doses for each Immunization OR dates for each immunization Software generated outcomes: whether a provider has immunization coverage above or below a specified threshold and option to produce immunization histories of not up-to-date clients as examples to discuss with the provider and staff	◆ Smallest sample size ◆ Rapid assessment ◆ Identifies providers who may benefit from a standard and more thorough assessment.	◆ Does not give point estimate of coverage. ◆ Smaller basis for diagnostic feedback – can only provide case by case examples.

Registry Based Assessment	Number of charts: all eligible records within the pre-determined age group Method for selecting charts: select all records within the specified age range Software to use: **CASA** Information entered into software: demographic and immunization data selected from registry Software generated outcomes: immunization coverage level, diagnostic information on late starts, drop-offs, missed opportunities, etc	◆ Minimal time and effort for data collection. ◆ No sampling error since estimates based on census of records.	◆ Potential bias if registry does not include all of the provider's records ◆ Potential bias if provider database does not include all historical records ◆ Reliability of registry data

* Before conducting an assessment, a specified age group to be included in the assessment should be determined and this group should be eligible for and assessed on the same immunizations (i.e. 50 children 12-23, 19-35 or 24-35; not 50 charts for children 12-35 months of age).

Resource 4 Feedback Session Checklist

The following feedback session checklist is provided as an example of a method to document the content and discussion of the feedback session. This checklist can be copied and used by the grantees, or the checklist can be customized to meet their needs. Some grantees may wish to create their own document to record the content and discussion of the feedback session.

EXAMPLE

Feedback Session Checklist

Directions: Complete provider information section. Place a check mark in each area that you addressed during your feedback session. Please document any significant findings or discussions in comment area of the appropriate section. Sign your name and date of follow-up or next assessment.

Provider Information:

Provider Name: _____ Date of Assessment: _____
Date of Feedback: _____ Office Contact: _____
Assessment Method: _____ Age Range Assessed: _____
Series Assessed: _____ Coverage Level: _____
Office Telephone: _____ Key Staff: _____
Staff Present for Feedback Session: _____

Feedback Content	Discussed	Comments
Areas of strength related to immunization delivery in practice.		
List at least 2 opportunities for improvement related to immunization delivery in practice.		**Opportunities for improvement discussed:** **1.** **2.** **3.** **4.**
Coverage level		Coverage level at _____ months Age range assessed Series assessed
Assessment reports used in feedback session		**Reports:** **1.** **2.** **3.** **Left with staff? Yes No**
Staff reaction to assessment findings		
Quality improvement plan developed for ___ opportunities for improvement		**Opportunities for improvement for QI plan:** **1.**
Written plan developed with staff (attach copy to this form)		
Resources/incentives left for office		**List resources/incentives:**
Follow-up commitments and due dates		**1.** **Date:** _____ **2.** **Date:** _____ **3.** **Date:** _____
Other comments:		

Field Staff: _____ Follow-up date or next assessment: _____

Resource 5 Opportunity for Improvement Intervention Handouts

The following documents are provided as examples of handouts that can be utilized during the Feedback session to discuss priority areas with opportunities for improvement. These handouts can be copied and used by the grantees, or the handouts can be customized to meet their needs. Some grantees may wish to create their own document to assist providers with improvement interventions.

EXAMPLE

Resource 5.1 Opportunity for Improvement - VACCINE STORAGE

Practice name: _____ VFC#: _____ Date: _____

Specific Opportunity	Recommended Actions
____A. Inadequate freezer used for Varivax storage.	1. Store Varivax in a stand-alone freezer or in a separate, sealed freezer compartment with a separate exterior door. Embedded freezers, which are part of a refrigerator/freezer combination but do not have a separate exterior door, are not acceptable. 2. Monitor both refrigerator and freezer temperatures to ensure that a refrigerator/freezer combination can maintain proper temperatures for both refrigerated and frozen vaccines.
____B. Working thermometer not present in every refrigerator and freezer used for vaccine storage. ____C. Refrigerator and freezer temperatures are not recorded daily for all units used for vaccine storage.	1. Ensure that a working thermometer is placed in all refrigerators and freezers used to store vaccine. 2. Formally designate one staff member (and a back-up for vacation coverage) to check and record temperatures for all refrigerators and freezers used to store vaccine. 3. Post temperature logs on refrigerator/freezer doors and submit with all vaccine orders.
____D. Recorded refrigerator and/or freezer temperatures not in range. Refrigerator: 35° – 46° F (2° - 8° C) Freezer: <5°F (<-15° C)	1. Ensure that a working thermometer is placed in all vaccine storage units and that temperatures are recorded 2. Ensure that all staff checking and recording temperatures are aware of the proper temperature ranges for vaccine storage. 3. Contact VFC Program for advice whenever temperatures are out of range.
____E. Short-dated vaccines in refrigerator or freezer. ____F. Expired vaccines in refrigerator or freezer.	1. Monitor vaccine usage and order only a 3-month supply at any one time. 2. Keep vaccine sorted by expiration date, and use oldest vaccine first. 3. Inventory vaccine at least monthly. Notify VFC Program of any short-dated vaccine – vaccine due to expire within 2 months. 4. Return all expired VFC vaccine to the VFC Program.
____G. Vaccine stored in refrigerator or freezer door.	1. Move to interior of unit to ensure temperature stability.
____H. Food stored in refrigerator or freezer.	1. Remove; food storage leads to more frequent opening of unit doors, causing temperature fluctuations.
____I. Unable to identify private stock vaccine vs. VFC vaccine. ____J. No private stock vaccine, but practice sees privately-insured patients.	1. Review VFC eligibility requirements with all staff. (Aged 0-18 years, uninsured or Medicaid-eligible.) 2. Check VFC eligibility of all patients. 3. Ensure that private stock vaccine is ordered to meet needs of non-VFC eligible patients.

EXAMPLE

Opportunities for Improvement - MISSED OPPORTUNITIES (MO)

Practice name: _____ VFC#: _____ Date: _____

Specific Opportunity	Suggestions
___ A. Does not follow the harmonized *Recommended Childhood Immunization Schedule*	1. Formally designate one staff member to coordinate/monitor all immunization activities, including disseminating immunization schedules, advisories, and communicating current practice policies to staff. 2. Establish a formal system to update and educate staff on immunization issues. 3. Regularly review the recommended schedule and/or guidelines with all clinicians and ensure all clinicians follow a common schedule. 4. Discuss accelerated schedule 5. Ensure minimum intervals are adhered to 6. Review recommended minimum age schedule 7. Discuss clinical outcomes of vaccinating too early (i.e. MMR and/or varicella administered before first birthday) 8. Administer age-appropriate immunizations if records from other providers are not available
___ B. Does not have a policy to screen charts before the patient sees the provider for immunizations due/overdue at every acute care, follow-up and well-child visit	1. Formally designate someone to review all immunization records before the patient is seen by the provider, and mark chart to prompt provider if immunizations are due 2. Adjust when the immunization records are reviewed (e.g. the day before the visit, the morning of the visit, when the patient arrives or during the visit). 3. Develop office policies and procedures to facilitate administration of immunizations by all staff (MDs, NPs, PAs, RNs, LPNs, MAs) 4. Cross train staff to cover for each other
___ C. Does not practice simultaneous administration (administers all necessary vaccines in one visit)	1. Review recommendation about simultaneous vaccination with all clinicians 2. If all immunizations are not given at one visit: - document reasons in progress notes - highlight the fact that immunizations are overdue - ensure patient follow-up is effective at getting patients in for subsequent visits
___ D. Does not follow the ACIP recommendations concerning valid contraindications	1. Make it a policy to give immunizations at every type of visit (acute, follow-up and well child visits), unless valid contraindications exist 2. Review valid contraindications with all clinicians 3. Provide clinicians with list of valid contraindications 4. Post immunization schedule as visual reminder 5. Post guide to valid contraindications as visual reminder 6. Review charts to see if children who didn't get immunizations at sick visits actually came back for follow-up and/or well child visits 7. If immunizations are postponed due to valid contraindications: - document reasons for postponement in progress notes - highlight the fact that immunizations are overdue - ensure patient follow-up is effective at getting patients back in for subsequent visits 8. Modify format of the progress notes to facilitate documentation of reasons for postponement

EXAMPLE

Opportunity Area - REMINDER/RECALL (R/R)

Practice name:_____ VFC#:_____ Date:_____

Specific Opportunity	Suggestions
___ A. Difficulty with patient follow-up	1. Formally designate one staff member to coordinate all reminder/recall activities and patient follow-up 2. Ensure all patients schedule next visit before leaving the office; if patients don't schedule the next appointment, make a note in log book or computer system to follow-up 3. Confirm current address and phone number at every visit 4. Send parents home with reminder card with appointment date 5. Determine a procedure for communicating patient follow-up instructions with front office staff 6. Coordinate with other clinicians and programs to pursue additional follow-up and outreach 7. Use a "No-Show" stamp to stamp chart: - on the outside cover - in the progress notes - record the date and reason for no show, if known 8. Call or send parents a reminder when they miss an appointment 9. Keep a log of all children who miss appointments 10. Document in patient's chart the date patient moves or goes elsewhere for care (MOGE)
___ B. Unable to generate or use a list of children due or overdue for immunizations	1. Establish a reminder/recall system or process to notify parents to bring their children in 2. Determine if computer systems currently used for billing and scheduling can be used to generate a list 3. Implement a computerized or manual immunizations tracking system 4. Flag, file separately or designate a special place to put charts of children as they are identified as needing immunizations 5. Keep a log of all children who are behind in the immunization schedule
___ C. Difficulty getting children in the door for immunizations	1. Send out reminder/recall notices at least twice a year (e.g. at 8 and 20 months of age) 2. Adjust office hours by holding evening or weekend hours 3. Offer more well-child, walk-in, or immunization-only visits 4. Regularly discuss the importance of immunizations with parent by offering information in a variety of formats and languages 5. Send parents home with educational material that specify which immunizations will be due at the next visit and a reminder card that states either: - the date and time of the next appointment - when to call to schedule an appointment 6. Remind parents prior to a scheduled visit either by a phone call or letter/postcard, or both 7. Send a letter to or call parents of newborns to welcome their baby into the practice and remind them of upcoming visits

EXAMPLE

___ D. Does not have a policy to screen charts before the patient sees the provider for immunizations overdue at every acute care, follow-up and well-child visit	1. Formally designate someone to screen all immunizations records before the patient is seen, and mark chart to prompt if immunizations are due 2. Adjust when the immunization records are reviewed (i.e. the day before the visit, the morning of the visit, when the patient arrives, or during the visit) 3. Develop office policies and procedures to facilitate administration of immunizations by all staff (MDs, NPs, Pas, RNs, LPNs, MAs) 4. Cross train staff to cover for each other

EXAMPLE

Opportunity for Improvement- DOCUMENTATION

Practice name:_____ VFC#:_____ Date:_____

Specific Opportunity	Suggestions
___ A. Does not consistently and accurately document immunizations according to the recommended guidelines	1. Formally designate one staff member to coordinate/monitor all immunization activities in the office, including reviewing documentation of immunizations. 2. Ensure that all vaccinated children have the appropriate documentation in their medical records according to ***National Childhood Vaccine Injury Act***: a. date of administration of the vaccine b. vaccine manufacturer and lot number of the vaccine c. the name and address and, if appropriate, the title of the health care provider administering the vaccine. d. VIS date 3. Provide patient, parent or legal guardian with a copy of the Vaccine Information Statement (VIS), with each dose of vaccine administered and answer any questions 4. Remind staff that reliable history of chickenpox disease is acceptable as proof of immunity if noted and dated (month and year minimum) in the chart 5. Ensure exemptions are appropriately documented before patient leaves the office 6. Ensure shots received elsewhere are always incorporated into the immunization record 7. Assist parent in obtaining records from other clinicians - preprinted request form - phone clinician if parent's attempts are unsuccessful 8. Create a system for locating historical immunization dates for new patients
___ B. Not able to easily locate the immunization record in the chart and identify which immunizations are due/overdue	1. Place the immunization records in a prominent, easy-to-find place in <u>every</u> chart (e.g. inside the front cover). 2. Use an immunization record that is easy to notice 3. Insert an age-specific visit encounter form that is pre-printed with the immunizations that are due at that age 4. Use a red ink to write the immunizations that are due on a visit form, in the progress notes, or any notes attached to the chart 5. Insert or clip parent education materials for immunizations due in or to the patient's chart

EXAMPLE

___ C. Does not consistently and properly document in the medical record patients who have moved or gone elsewhere (MOGE) for care	1. Document patients who may have moved or gone elsewhere with any of the following: - written documentation that the patient has transferred - a letter from another clinician that the patient is in a new practice - written documentation that the patient has moved (returned letter, registered letter, or card) Unacceptable documentation of MOGE includes: - documentation of unsuccessful telephone attempts - documentation of a letter or card sent with no confirmation of receipt - documentation of multiple "no shows" 2. Increase efforts to locate MOGEs using letters, cards or registered letters – if returned, place in the patients' charts 3. Increase efforts to obtain written confirmation that a patient has transferred to another practice.

Resource 5.2 Opportunities for Improvement Worksheet

The following worksheet is provided as an example of a document that can be used to record the opportunity for improvement selected by the office staff and interventions to improve the immunization delivery. This worksheet can be copied and used by the grantees or customized to meet their needs. Some grantees may wish to create their own document to record quality improvement activities at the provider level.

5.2 Opportunities for Improvement Worksheet

Provider Name:
Date of Feedback:
Name of Assessment Coordinator:
Name of Office Contact:
Estimated Date of Next Follow Up:

Opportunities for Improvement	Action Plan	Responsible Individual(s)	Start Date	Follow up Date	Outcome